**DRNS Knowledge Exchange Event: Palliative and end-of-life care for people who use drugs**

**Discussion Points and Questions**

**How are patient groups engaging with palliative care?**

* Engagement depends on the key worker and how the care is presented. Past experience tends to be good, however it can be difficult to get over the initial hurdle of apprehension.
* It is essential to have joined up working, patients should be reassured that teams work together. Addictions teams will still be part of a patients care plan.

**For palliative management of pain, are patients reporting hesitation of prescribing due to fear of worsening ‘addiction’ or is it more commonly due to fear of illicit use and overdose death?**

* The perception is the fear of diversion; illicit use and overdose might inhibit treatment.

**Are patients referred to palliative care who are nearing end of life solely due to their drug use, (rather than dying with drug use alongside something like cancer)?**

* Referral is based entirely on palliative care needs.

**Thoughts on the use of MR Morphine for combination treatment of opioid dependence and pain in palliative care – replacing other, previously prescribed, OST treatments?**

* Avoid changing the Methadone, often patients are not keen for it to be increased if they have spent a lot of time and effort reducing dose.
* Sometimes will convert to morphine alone and stop methadone or buprenorphine, however this is only after discussions with the patient.
* Is there a methadone to morphine conversion or is it variable?
* Opioid conversion charts are not exact – they are designed to be safe – however there will be huge interindividual variation as well as issues of oral absorption that need to be considered.
* Caution should be taken when doing a conversion with morphine and methadone to a fentanyl patch as there are issues with the long half-life of methadone, absorption etc., - would consider as inpatient only.

**Idea of a joint Palliative Medicine/Addictions team/AHP out-patient clinic perhaps monthly? Is there any experience of this, or are joint home visits with the key worker felt to be a better option?**

* In Lanarkshire there isn’t the numbers to justify a clinic, however every health board is different. A joint clinic would be the gold standard.

**What stigmas/discrimination might surround PWUDs with a terminal cancer diagnosis?**

* Fear of withdrawal.
* Not engaging with services, however they may be unable to engage because the services aren’t tailoring the support to the individual.
* Prejudice.
* Guilt / not worthy

**The emotional impact of this work upon practitioners: what support is available / unavailable?**

* End of life and loss of life discussion groups with peer support.
* Team leader and peer support / de-brief.

**Other points:**

* Sometimes professionals are not confident in substance and pain prescribing which can result in not managing it correctly, often leaving people using more illicit drugs for pain control.
* Palliative care for people in isolated situations?
* In Liverpool there is a new specialist homeless palliative care nurse who is working with hostels and homeless services; encouraging substance use staff to reach out to palliative services for advice when concerned about someone they’re working with; there is a new ‘hub’ model for palliative care – whereby patients and family carers can phone directly for advice and support to access the right part of the palliative care system; and finally, colleagues in Manchester are producing a range of leaflets and resources to provide advice to: (1) people approaching the end of their life; (2) family carers, and (3) health and social care practitioners.
* Opioid induced hyperalgesia is very difficult to diagnose as patients often describe increases in opioid dose, however this is often unclear and reducing dose in someone with a reason for pain is risky.